Complete Summary

GUIDELINE TITLE

Guideline on oral and dental aspects of child abuse and neglect.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatric Dentistry (AAPD). Guideline on oral and dental aspects of child abuse and neglect. Chicago (IL): American Academy of Pediatric Dentistry (AAPD); 2005. 4 p. [33 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
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INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
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SCOPE

DISEASE/CONDITION(S)

Oral and dental injuries due to child abuse and neglect

GUIDELINE CATEGORY

Evaluation
Prevention
Screening

CLINICAL SPECIALTY

Dentistry
Pediatrics

INTENDED USERS

Dentists
Physicians

GUIDELINE OBJECTIVE(S)

- To review the oral and dental aspects of physical and sexual abuse and dental neglect and the role of physicians and dentists in evaluating such conditions
- To encourage physicians and dentists to collaborate to increase the prevention, detection, and treatment of child abuse and neglect

TARGET POPULATION

Pediatric dental patients suspected of having been physically or sexually abused

INTERVENTIONS AND PRACTICES CONSIDERED

1. Intraoral and perioral examination
2. Examination also for caries, gingivitis, and other oral health problems
3. Testing for sexually transmitted diseases
4. Referral to specialist
5. Reporting cases of suspected abuse or neglect to appropriate authorities
6. Examination and evaluation of bite marks including photographing and making polyvinyl siloxane impressions
7. Collection of saliva and cells for DNA testing
8. Evaluation for dental neglect

MAJOR OUTCOMES CONSIDERED

Identification of child abuse or dental neglect

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The oral health policies and clinical guidelines of the American Academy of Pediatric Dentistry (AAPD) are developed under the direction of the Board of Trustees, utilizing the resources and expertise of its membership operating through the Council on Clinical Affairs (CCA).

Proposals to develop or modify policies and guidelines may originate from 4 sources:

1. The officers or trustees acting at any meeting of the Board of Trustees
2. A council, committee, or task force in its report to the Board of Trustees
3. Any member of the AAPD acting through the Reference Committee hearing of the General Assembly at the Annual Session
4. Officers, trustees, council and committee chairs, or other participants at the AAPD's Annual Strategic Planning Session.

Regardless of the source, proposals are considered carefully, and those deemed sufficiently meritorious by a majority vote of the Board of Trustees are referred to the CCA for development or review/revision.

Once a charge (directive from the Board of Trustees) for development or review/revision of an oral health policy or clinical guideline is sent to the CCA, it is assigned to 1 or more members of the CCA for completion. CCA members are instructed to follow the specified format for a policy or guideline. All oral health policies and clinical guidelines are based on 2 sources of evidence: (1) the scientific literature; and (2) experts in the field. Members may call upon any expert as a consultant to the council to provide expert opinion. The Council on Scientific Affairs provides input as to the scientific validity of a policy or guideline.

The CCA meets on an interim basis (midwinter) to discuss proposed oral health policies and clinical guidelines. Each new or reviewed/revised policy and guideline is reviewed, discussed, and confirmed by the entire council.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Once developed by the Council on Clinical Affairs (CCA), the proposed policy or guideline is submitted for the consideration of the Board of Trustees. While the board may request revision, in which case it is returned to the council for modification, once accepted by majority vote of the board, it is referred for Reference Committee hearing at the upcoming Annual Session. At the Reference Committee hearing, the membership may provide comment or suggestion for alteration of the document before presentation to the General Assembly. The final document then is presented for ratification by a majority vote of the membership present and voting at the General Assembly. If accepted by the General Assembly, either as proposed or as amended by that body, the document then becomes the official American Academy of Pediatric Dentistry (AAPD) oral health policy or clinical guideline for publication in the AAPD's Reference Manual and on the AAPD's Web site.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Physical Abuse

A careful and thorough intraoral and perioral examination is necessary in all cases of suspected abuse and neglect. In addition, all suspected victims of abuse or neglect, including children in state custody or foster care, should be examined carefully not only for signs of oral trauma but also for caries, gingivitis, and other oral health problems.

Some serious injuries of the oral cavity, including posterior pharyngeal injuries and retropharyngeal abscesses, may be inflicted by caregivers with factitious disorder by proxy to simulate hemoptysis or other symptoms requiring medical care; regardless of caregiver motive, all inflicted injuries should be reported for investigation. Unintentional or accidental injuries to the mouth are common and must be distinguished from abuse by judging whether the history, including the timing and mechanism of injury, is consistent with the characteristics of the injury and the child's developmental capabilities. Multiple injuries, injuries in different stages of healing, or a discrepant history should arouse a suspicion of abuse. Consultation with or referral to a knowledgeable dentist may be helpful.

Sexual Abuse

When oral-genital contact is suspected, referral to specialized clinical settings equipped to conduct comprehensive examinations is recommended.

When oral-genital contact is confirmed by history or examination findings, universal testing for sexually transmitted diseases within the oral cavity is controversial; the clinician should consider risk factors (e.g., chronic abuse, perpetrator with a known sexually transmitted disease) and the child's clinical presentation in deciding whether to conduct such testing. Although human papillomavirus infection may result in oral or perioral warts, the mode of transmission remains uncertain and debatable.

Unexplained injury or petechiae of the palate, particularly at the junction of the hard and soft palate, may be evidence of forced oral sex. As with all suspected child abuse or neglect, when sexual abuse is suspected or diagnosed in a child, the case must be reported to child protective services and/or law enforcement agencies for investigation. A multidisciplinary child abuse evaluation for the child and family should be initiated.

Children who present acutely with a recent history of sexual abuse may require specialized forensic testing for semen and other foreign materials resulting from assault. If a victim provides a history for oral-penile contact, the buccal mucosa and tongue can be swabbed with a sterile cotton-tipped applicator, then the swab can be air-dried and packaged appropriately for laboratory analysis. However, specialized hospitals and clinics equipped with protocols and experienced personnel are best suited for collecting such material and maintaining a chain of evidence necessary for investigations.

Bite Marks

Acute or healed bite marks may indicate abuse. Dentists trained as forensic odontologists can assist physicians in the detection and evaluation of bite marks related to physical and sexual abuse. Bite marks should be suspected when ecchymoses, abrasions, or lacerations are found in an elliptical or ovoid pattern. Bite marks may have a central area of ecchymoses (contusions) caused by 2 possible phenomena: positive pressure from the closing of the teeth with disruption of small vessels; or negative pressure caused by suction and tongue thrusting. Bites produced by dogs and other carnivorous animals tend to tear flesh. Whereas, human bites compress flesh and can cause abrasions, contusions, and lacerations but rarely avulsions of tissue. An intercanine distance (i.e., the linear distance between the central point of the cuspid tips) measuring more than 3.0 cm is suspicious of an adult human bite.

The pattern, size, contour, and color of the bite mark should be evaluated by a forensic odontologist or a forensic pathologist if an odontologist is not available. If neither specialist is available, a physician or dentist experienced in the patterns of child abuse injuries should observe and document the bite mark characteristics photographically with an identification tag and scale marker (e.g., ruler) in the photograph. The photograph should be taken such that the angle of the camera lens is directly over the bite and perpendicular to the plane of the bite to avoid distortion. A special photographic scale was developed by the American Board of Forensic Odontology (ABFO) for this purpose as well as for documenting other patterned injuries and can be obtained from the vendor (ABFO No. 2 reference

scale, available from Lightening Powder Co Inc, Salem, Ore). Names and contact information for ABFO certified odontologists can be obtained from the ABFO Web site (www.abfo.org).

In addition to photographic evidence, every bite mark that shows indentations should have a polyvinyl siloxane impression made immediately after swabbing the bite mark for secretions containing DNA. This impression will help provide a 3-dimensional model of the bite mark. Written observations and photographs should be repeated daily for at least 3 days to document the evolution of the bite. Because each person has a characteristic bite pattern, a forensic odontologist may be able to match dental models (casts) of a suspected abuser's teeth with impressions or photographs of the bite.

Blood group substances can be secreted in saliva. DNA is present in epithelial cells from the mouth and may be deposited in bites. Even if saliva and cells have dried, they should be collected using the double-swab technique. First, a sterile cotton swab moistened with distilled water is used to wipe the area in question, dried, and placed in a specimen tube. A second sterile dry cotton swab cleans the same area, then is dried and placed in a specimen tube. A third control sample should be obtained from an uninvolved area of the child's skin. All samples should be sent to a certified forensic laboratory for prompt analysis. The chain of custody must be maintained on all samples submitted for forensic analysis. Questions regarding evidentiary procedure should be directed to a law enforcement agency.

Dental Neglect

Dental neglect, as defined by the American Academy of Pediatric Dentistry, is the "willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection." Dental caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function. These undesirable outcomes can adversely affect learning, communication, nutrition, and other activities necessary for normal growth and development. Some children who first present for dental care have severe early childhood caries (formerly termed "baby bottle" or "nursing" caries); caregivers with adequate knowledge and willful failure to seek care must be differentiated from caregivers without knowledge or awareness of their child's need for dental care in determining the need to report such cases to child protective services.

Failure to seek or obtain proper dental care may result from factors such as family isolation, lack of finances, parental ignorance, or lack of perceived value of oral health. The point at which to consider a parent negligent and to begin intervention occurs after the parent has been properly alerted by a health care professional about the nature and extent of the child's condition, the specific treatment needed, and the mechanism of accessing that treatment. Because many families face challenges in their attempts to access dental care or insurance for their children, the clinician should determine whether dental services are readily available and accessible to the child when considering whether negligence has occurred.

The physician or dentist should be certain that the caregivers understand the explanation of the disease and its implications and, when barriers to the needed

care exist, attempt to assist the families in finding financial aid, transportation, or public facilities for needed services. Parents should be reassured that appropriate analgesic and anesthetic procedures will be used to ensure the child's comfort during dental procedures. If, despite these efforts, the parents fail to obtain therapy, the case should be reported to the appropriate child protective services agency.

Conclusions

Pediatricians should be aware that physical or sexual abuse may result in oral or dental injuries or conditions that sometimes can be confirmed by laboratory findings. Furthermore, injuries inflicted by one's mouth or teeth may leave clues regarding the timing and nature of the injury as well as the identity of the perpetrator. Pediatricians are encouraged to be knowledgeable about such findings and their significance and to meticulously observe and document them. When questions arise or when consultation is needed, a pediatric dentist or a dentist with formal training in forensic odontology can ensure appropriate testing, diagnosis, and treatment.

Pediatric dentists and oral and maxillofacial surgeons, whose advanced education programs include a mandated child abuse curriculum, can provide valuable information and assistance to physicians about oral and dental aspects of child abuse and neglect. The Prevent Abuse and Neglect Through Dental Awareness [also known as PANDA; telephone (501) 661-2595 or e-mail Lmouden@healthyarkansas.com] coalition, which has trained thousands of physicians, nurses, teachers, child care providers, dentists, and dental auxiliaries, is another resource for physicians seeking information on this issue. Physician members of multidisciplinary child abuse and neglect teams are encouraged to identify such dentists in their communities to serve as consultants for these teams. In addition, physicians with experience or expertise in child abuse and neglect can make themselves available to dentists and to dental organizations as consultants and educators. Such efforts will strengthen our ability to prevent and detect child abuse and neglect and enhance our ability to care for and protect children.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated for each recommendation. In general, all oral health policies and clinical guidelines are based on 2 sources of evidence: (1) the scientific literature; and (2) experts in the field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate identification of child physical or sexual abuse

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatric Dentistry (AAPD). Guideline on oral and dental aspects of child abuse and neglect. Chicago (IL): American Academy of Pediatric Dentistry (AAPD); 2005. 4 p. [33 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005

GUIDELINE DEVELOPER(S)

American Academy of Pediatric Dentistry - Professional Association
American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Pediatric Dentistry and the American Academy of Pediatrics

GUIDELINE COMMITTEE

American Academy of Pediatrics' Committee on Child Abuse and Neglect

American Academy of Pediatric Dentistry Council on Clinical Affairs

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

American Academy of Pediatrics' Committee on Child Abuse and Neglect 2004-2005 Members: Robert W. Block, MD, Chairperson; Roberta A. Hibbard, MD; Carole Jenny, MD; Nancy Kellogg, MD; Betty S. Spivack, MD

Section Representative: John Stirling, Jr, MD

Liaison Representatives: Joanne Klevens, MD, MPH, Centers for Disease Control and Prevention; David Corwin, MD, American Academy of Child and Adolescent Psychiatry

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American Academy of Pediatric Dentistry: Not identified

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

American Academy of Pediatric Dentistry council members are asked to identify potential conflicts of interest; none was disclosed.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Pediatric Dentistry Web site.

Print copies: Available from the American Academy of Pediatric Dentistry, 211 East Chicago Avenue, Suite 1700, Chicago, Illinois 60611

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Overview. American Academy of Pediatric Dentistry 2007-08 definitions, oral health policies, and clinical guidelines. Available in Portable Document Format (PDF) from the American Academy of Pediatric Dentistry Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on August 8, 2007. The information was verified by the guideline developer on August 23, 2007.

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Date Modified: 9/15/2008


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